STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nanci Norris-Pryzdia,

Petitioner,

14IWCC0319

vs.

NO: 11 WC 07569

The DeLong Co., Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues medical expenses, prospective medical care, temporary total disability benefits, and penalties under Section 19(l) of the Act, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's factual summary and ultimate findings and awards; however, the Commission supplements the Decision in order to specifically address when entitlement to the penalty award began.

The Commission notes that during his September 19, 2012 evidence deposition, Respondent's Section 12 examiner, Dr. Kevin Tu, initially opined that Petitioner's need for total knee replacement surgery "was because of the degenerative changes in her medial compartment. So if we divide the knee up into three compartments, the anterio is the front of the knee where the patellofemoral compartment is. It's essentially underneath the knee cap. The medial compartment is with the inner portion of the knees, touch each other, and then the latter portion is the outside portion of the knee, and the weightbearing area of the knee is the medial, or weightbearing areas are the medial and lateral parts of the knee joint. And I felt that she, when she fell, she did aggravate the arthritis in front of her knees at the anterior compartment, but the reason why she needed the knee replacements was because of the progression of the arthritic changes in her medial compartment, and that thought progression, or those changes that progressed were just a natural history for the pre-existing degenerative changes in her knee."

(RX1-pgs.7-8) However, on cross-examination, Dr. Tu acknowledged that the August 17, 2009 fall could possibly be a factor in Petitioner's need for total knee replacement surgery. (RX1-pgs.30-31) At that point, Respondent was on notice Dr. Tu's original causation opinion regarding Petitioner's need for total knee replacement surgery had changed and linked Petitioner's need for the total knee replacement surgery to the August 17, 2009 fall.

Section 19(l) of the Act states, in pertinent part, that if an employer or its insurance carrier "fail, neglect, refuse, or unreasonably delay" the payment of benefits under Sections 8(a) and 8(b) "without good and just cause," then the claimant shall be entitled to additional compensation in the sum of $30 per day "***for each day that the benefits*** under Section 8(a) or Section 8(b) ***have been so withheld or refused***, not to exceed $10,000." 820 ILCS 305/19(l) (2007) (emphasis added). The court in *Jacobo v. Illinois Workers' Compensation Commission*, 2011 IL App (3d) 100807WC, ¶20, explained that the standard for determining whether an employer has good and just cause for a delay in payment is the reasonableness of the delay. The Commission finds that Respondent's continued denial of the requested total knee replacement surgery based on Dr. Tu's original causation opinion and decision to ignore Dr. Tu's acknowledgement of the link between Petitioner's need for total knee replacement surgery and the work accident unreasonable. Respondent did not provide a good and just reason for its continued denial of the surgery once Dr. Tu acknowledged the link between Petitioner's need for additional surgery and the August 17, 2009 fall. Furthermore, the Commission finds that while Dr. Tu made this acknowledgement during his September 19, 2012 evidence deposition, Respondent has withheld authorization for the total knee replacement surgery since it was first ordered by Dr. Robert Daley on March 24, 2011. (PX5)

Section 19(l) plainly states that a penalty of $30 a day shall be assessed for "each day that the benefits...have been withheld or refused." 820 ILCS 305/19(l) (2007). Respondent started refusing authorization for the total knee replacement surgery on March 24, 2011. The Commission finds that Respondent refused and withheld the required treatment from March 24, 2011 through July 23, 2013 (date of hearing), totaling 853 days. (853 x $30=$25,590.00) However, Section 19(l) only allows penalties under this section up to $10,000.00. Therefore, the Commission finds that Petitioner is entitled to penalties under Section 19(l) totaling $10,000.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 29, 2013, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $446.36 per week for a period of 45-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,497.36 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner penalties of $10,000.00, as provided in Section 19(l) of the Act.

14IWCC0319

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and provide for prospective and ancillary medical care as prescribed by Dr. Robert Daley.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 1 2014
MJB/ell
o-04/08/14
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

14IWCC0319

NORRIS-PRYZDIA, NANCI
Employee/Petitioner

Case# 11WC007569

THE DELONG CO INC
Employer/Respondent

On 8/29/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0140 CORTI ALEKSY & CASTANEDA PC
RICHARD E ALEKSY
180 N LASALLE ST SUITE 2910
CHICAGO, IL 60601

0332 LIVINGSTONE MUELLER ET AL
D SCOTT MURPHY
620 E EDWARDS ST PO BOX 335
SPRINGFIELD, IL 62705

14IWCC0319

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

NANCI NORRIS-PRYZDIA
Employee/Petitioner

v.

THE DELONG CO. INC.
Employer/Respondent

Case # **11** WC **07569**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **George Andros**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 23, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☐ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Prospective medical treatment**

14IWCC0319

FINDINGS

On **8/17/2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $34,816.08; the average weekly wage was $669.54.

On the date of accident, Petitioner was 45 years of age, ***single*** with 0 dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $1,530.37 for TTD, $0 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $1,530.37.

Respondent is entitled to a credit of $0 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $446.36/week for 45 $^{4}/_{7}$ weeks, commencing 3/9/2010 to 3/21/2010 and 5/4/2010 to 5/16/2010 and 11/2/2011 to 8/20/2012, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $1,497.36, as provided in Section 8(a) of the Act.

Respondent shall pay to Petitioner penalties of $0, as provided in Section 16 of the Act; $0, as provided in Section 19(k) of the Act; and $10,000.00, as provided in Section 19(l) of the Act.

Respondent shall authorize and provide for prospective & ancillary medical care as prescribed by Robert Daley, M.D.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

/s/ George J. Andros

Signature of Arbitrator

August 14th, 2013

Date

AUG 29 2013

STATEMENT OF FACTS 11 WC 07569

Petitioner, Nanci Norris-Pryzdia, was employed by Respondent, The DeLong Company, as a grain weigher and tester. Her duties included weighing the incoming trucks loaded with grain, using a joystick to remove samples of the grain from each load, testing the samples, then carrying the tested materials to the dock in five-gallon containers.

The parties stipulated that Claimant sustained an accidental injury on August 17, 2009: as Petitioner approached the staircase leading to the employee entrance, she saw that the lower steps were covered in water because of prior rain; therefore, Ms. Norris-Pryzdia had to try to jump over the water area to reach the first dry step. As she jumped, she tripped over a piece of exposed metal extending from the stair. Claimant landed directly on both knees then fell backwards, injuring both knees, her neck and her back. Approximately a week later, she was evaluated by her family physician, Dr. Manoogian, who detailed the history of injury and complaints of injuries to both knees as well as headaches. Following his examination, the doctor referred her to an orthopedic specialist, Dr. Robert Atkenson.

The initial consultation with Dr. Atkenson took place on August 27, 2009. The notes from that visit reflect a history of injury consistent with Petitioner's testimony regarding the stipulated accident. Examination showed profound bilateral patellofemoral crepitation, grinding test was four plus bilaterally, superficial partial thickness abrasion was present, as well as prepatellar effusion. X-rays were performed and Dr. Atkenson determined that Claimant should attend physical therapy and start taking Glucosamine. In the interim, she could continue to work.

Therapy was commenced at ATI on August 31, 2009 and continued for several weeks. Claimant then followed up with Dr. Atkenson on September 28, 2009. She reported that the therapy was not helping and her bilateral anterior and posterior knee pain persisted. The doctor recommended Supartz injections but maintained her full duty work status. Thereafter the doctor performed a series of five Supartz injections, one per week starting on October 1, 2009 and ending with the fifth injection on October 29, 2009. When Petitioner returned to see Dr. Atkenson on November 19, 2009, she reported that her pain persisted. The doctor advised her to use Voltaren gel, commence a weight reduction program and to follow up with him.

At the December 21, 2009 appointment, when Ms. Norris-Pryzdia advised that she still had consistent pain, Dr. Atkenson concluded that an arthroscopic procedure of the left knee would be appropriate. Prior to the commencement of that surgical intervention, Claimant was sent by Respondent to Dr. Kevin Tu for a section 12 exam examination which occurred on January 28, 2010. In his report of that date the doctor determined that the work injury of August 17 aggravated a preexisting condition and that it may also have caused a new chondral injury to the patellofemoral joint compartment which he concluded was responsible for her current symptoms. He noted that she had failed conservative treatment and determined that a left knee arthroscopy with chondroplasty of the patellofemoral joint compartment would be reasonable. He opined that her prognosis was guarded but she should receive the surgical intervention.

On March 9, 2010, Ms. Norris-Pryzdia underwent an arthroscopy of the left knee with extensive debridement. The postoperative diagnosis was osteoarthritis, patellofemoral and medial compartment arthritis with contusion of the left knee. Petitioner followed up with Dr. Atkenson a week later. On exam, the doctor noted an absence of crepitation but a small amount of effusion; he ordered a course of physical therapy and released her to return to work as of March 22, 2010.

Claimant returned to her pre-injury job on March 22, 2010, and attended the recommended therapy at ATI which ended on April 12, 2010. On that date she saw Dr. Atkenson in follow up and he determined that the progress made on the left knee was acceptable; with respect to her right knee, she had prominent crepitation and the doctor concluded that arthroscopic repair was necessary. Claimant continued working then underwent the right knee arthroscopy on May 4, 2010, with the doctor performing extensive debridement and abrasion of arthroplasty in areas of exposed subchondral bone. One week later, she returned to see the physician for postoperative suture removal. Dr. Atkenson determined that she had progressed enough to return to work while undergoing physical therapy. This therapy commenced on May 11, 2010 and continued through July 1, 2010. Claimant returned to work on May 17, 2010.

Ms. Norris-Pryzdia saw Dr. Manoogian on December 10, 2010 in order to get a prescription for pain medication. As she was still in pain, the doctor directed that she seek a second opinion. As such, Claimant consulted with Dr. Robert Daley from Hinsdale Orthopaedics on February 10, 2011. The notes from that visit include a consistent history of injury, and reflect that she had had prior discomfort occasionally in her knees, but she had never experienced anything as severe as she was experiencing at that juncture. After an exam, he discerned that Ms. Norris-Pryzdia might be a candidate for a patellofemoral replacement or total knee replacement, but he wanted to review her operative photos from the prior arthroscopies before making a definitive treatment plan. Dr. Daley concluded that her current condition of ill-being was related to the fall at work. Also, since she continued to complain of neck and back pain, he referred her to his colleague in the same practice, Dr. Marie Kirincic.

Dr. Kirincic's involvement commenced on February 18, 2011. Claimant described her current condition of ill-being as it related to her back and neck both prior to the stipulated injury as well as the post-injury discomfort which she attributed to her limping. The doctor reviewed the MRIs and noted degenerative arthritis of the lumbosacral spine most pronounced at L4-5, with small to moderate left paracentral L5-S1 disc herniation with absence of significant central spinal stenosis. X-rays were taken of the cervical spine which showed loss of cervical lordosis, slight cervicothoracolumbar curvature. The lumbar spine showed degenerative changes, especially at L4 through S1 with facet arthropathy distally but no marked spondylolisthesis. Dr. Kirincic's diagnosis was diffused myofascial pain, altered gait due to knee surgery, degenerative disc disease at L4 through S1 and a small left L5-S1 herniated disc as well as possible fibromyalgia. The doctor directed that Petitioner obtain a rheumatoid blood panel, prescribed Cymbalta, Mobic and a TENS unit, and ordered physical therapy as well as trigger point injections. Claimant was given a trigger point injection in the bilateral piriformis and gluteals that day.

Thereafter, Petitioner returned to see Dr. Daley but was interviewed by his physician assistant, Nathan Hawkins. The operative video was reviewed and the conclusion was that she should undergo an MRI, but she did not appear to be a candidate for a patellofemoral replacement.

On March 11, 2011, Ms. Norris-Pryzdia underwent an MRI of the right knee; it revealed severe patellofemoral chondromalacia involving both patellar facets and the medial and lateral femoral trochlea to a lesser degree with subtle subchondral osseous reaction, moderate lateral tibial plateau fissuring without significant osseous reaction, mild medial femoral condylar chondral fissuring, but no ligament tears were noted.

Claimant saw Dr. Daley to review the MRI on March 24, 2011. The doctor's diagnosis was severe bilateral knee chondral damage following a work injury with continued pain and discomfort. It was his opinion that she needed total knee replacement.

On May 12, 2011, Petitioner attended a second §12 examination with Dr. Kevin Tu. In his report, the doctor notes that Claimant continued to have persistent pain in both her knees. The doctor's examination indicated that she presented with mild patellar femoral irritability with patellofemoral crepitation present in the left. In the right knee there was medial joint line tenderness and lateral joint line tenderness without effusion. He then went on to review all of the medical records. The doctor concluded that there was an aggravation of the preexisting patellofemoral arthritis but she was at maximum medical improvement and the need for the bilateral total knee arthroplasties was secondary to the natural progression of the degenerative changes in her medial compartment. He did add, however, that a fall to the anterior aspect of the knee could aggravate arthritic changes in the patellofemoral condyle compartment, but felt it was unlikely to aggravate preexisting degenerative changes in the weight bearing zones of the medial femoral condyle.

Following this visit with Dr. Tu, Ms. Norris-Pryzdia returned to see Dr. Daley. The doctor reiterated that she had failed conservative treatment and needed total knee replacement. He indicated he would attempt to obtain approval from workers' compensation and directed that she remain off work. Thereafter, Petitioner followed up with Dr. Daley from time to time and he continued to maintain his surgical recommendation as well as her off work status. The depositions of Dr. Daley as well as Dr. Tu were offered into evidence by the respective parties and studied and taken into consideration in this Award.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

WITH REGARD TO THE ISSUE OF WHETHER THE PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Supreme Court has determined that even though a workers' compensation claimant may have a preexisting condition which may make him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor. Sisbro, Inc. v. Industrial Commission, 207 Ill.2d 193 (2003). A chain of events showing a prior condition of good health, followed by a sudden change after a work injury, can establish causation. Illinois Power Co. v. Industrial Commission, 176 Ill.App.3d 317 (4th Dist. 1988). "The rationale justifying the use of the 'chain of events' analysis to demonstrate the existence of an injury would also support its use to demonstrate an aggravation of a preexisting injury." Price v. Industrial Commission, 278 Ill.App.3d 848,854 (4th Dist. 1996). Having reviewed the medical records and deposition testimony, as well as Ms. Norris-Pryzdia's very credible and forthright testimony regarding her persistent symptoms, the Arbitrator concludes that the nature of the accident as stipulated to by the parties, as well as the preponderance of the medical evidence including the records of Dr. Atkenson and Dr. Daley, as well as Dr. Daley's testimony on deposition and the deposition of Dr. Tu, establish a direct causal connection between Petitioner's undisputed accident and her current condition of ill-being which Dr. Daley has concluded requires ongoing medical treatment.

Thus, the Arbitrator based upon the totality of the evidence finds by a preponderance of that evidence the accident in the case at bar is causally connected as a matter of fact and as a matter of law to her current condition of ill being as alleged herein.

WITH REGARD TO THE ISSUE OF WHETHER THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER WERE REASONABLE AND NECESSARY AND WHETHER THOSE CHARGES HAVE BEEN PAID, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Petitioner commenced treatment with Dr. Atkenson for her knee injuries shortly after the date of injury and those medical expenses apparently have been borne by Respondent.

The Arbitrator has determined that the medical expenses contained in Petitioner's exhibit for the treatment rendered by Dr. Manoogian on August 25, 2009 as well as the treatment provided by Dr. Daley from February 10, 2011 through December 28, 2012 are reasonable and necessary under section 8 as a matter of fact and as a matter of law.

The balances are shown by the exhibit offered by Petitioner total $1,497.36. The Arbitrator finds as a matter of fact and matter of law they are reasonable, necessary and related thus hereby orders the above amount to be paid to the Petitioner and his attorney.

WITH REGARD TO WHAT PERIODS OF TEMPORARY BENEFITS ARE IN DISPUTE AND ARE APPROPRIATE TO BE AWARDED, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained lost time and received benefits commencing on March 9, 2010 through March 21, 2010 and then a second period of May 4, 2010 through May 16, 2010. These periods correspond to the periods of lost time following the surgical interventions of Dr. Atkenson when he performed the arthroscopic procedures, first on the left knee and then the right knee. Respondent has acknowledged liability for and paid TTD benefits for these periods.

What is disputed is the lost time as of November 2, 2011, when Dr. Daley determined that she should remain off work pending surgical intervention for a total knee replacement. Ms. Norris-Pryzdia remained off work pursuant to Dr. Daley's directive until August 20, 2012, when she began a very sedentary job at the NICL Lab, where she worked for several months and then obtained a new position at her current employment, The Adventist Lab.

Having concluded that Petitioner's condition of ill-being remains causally connected to her undisputed accident and she requires the surgical intervention recommended by Dr. Daley, the Arbitrator concludes that Petitioner was temporarily totally disabled under the orders of Dr. Daley from November 2, 2011 through August 20, 2012. The medical records of Dr. Daley and his position that Claimant should not return to work remained the same up to his last visit with Petitioner, however Petitioner testified that she returned to work because she had been receiving no benefits.

Therefore, based upon the totality of the evidence and in particular, adoption of the opinions of Dr. Daley, the Arbitrator concludes as a matter of fact and of law that Petitioner in the case at bar is entitled to temporary total disability benefits from November 2, 2011 through August 20, 2012, a period of 41 $^{6}/_{7}$ weeks.

WITH REGARD TO THE ISSUE OF WHETHER PENALTIES OR FEES SHOULD BE IMPOSED UPON RESPONDENT, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

Tu's testimony demonstrates that Dr. Tu did not have any real concerns about the treatment as directed by Dr. Daley; to wit: his report in fact acknowledged that the undisputed accident resulted in an aggravation. Respondent nonetheless failed to provide the authorization for the necessary treatment and refused to pay Temporary Total Disability benefits.

He who delays payment of workers' compensation benefits bears the burden of excusing the delay when a penalty for unreasonable and vexatious delay in payment is sought (City of Chicago v. Industrial Commission, 63 Ill.2d 99 (1976)), yet there was no evidence offered on behalf of Respondent as to why it failed to pay this compensation.

The Arbitrator finds as a matter of fact and of law that Respondent failed to establish good or just cause for its refusal to pay. See, McMahan v. Industrial Commission, 183 Ill.2d 499, 515 (1998) ("The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment 'without good and just cause.' If the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay, an award of the statutorily specified additional compensation is mandatory.")

Therefore, the Arbitrator finds as a matter of fact and of law under section 19 that Petitioner is entitled to $30.00 per day for each day that she has not received this temporary total disability benefit. The Arbitrator concludes that failure to pay these benefits commencing on November 2, 2011 up to the date of hearing results in the maximum penalty payable in the amount of $10,000.00.

WITH REGARD TO THE ISSUE OF PENALTIES UNDER SECTION 19(k) AND ATTORNEY'S FEES PURSUANT TO SECTION 16, THE ARBITRATOR FINDS THE FOLLOWING FACTS:

The Arbitrator is cognizant of the fact that the Appellate and Supreme Courts have determined that there is an elevated standard for the imposition of Section 19(k) penalties and attorney's fees under Section 16. Although the testimony of Dr. Tu seems to remove any doubt that Petitioner's condition of ill-being requires the surgical intervention as outlined by Dr. Daley and that it certainly is related to the accident event as testified to, the Arbitrator is reluctant to impose this more severe sanction on Respondent.

Therefore, as a matter of fact and as a conclusion of law penalties pursuant to Section 19(k) and attorney's fees pursuant to Section 16 are denied.

WITH REGARD TO THE ISSUE OF PROSPECTIVE MEDICAL, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator adopts the testimony of Dr. Daley, as well as his medical records, the diagnostic studies that have been performed, and his surgical recommendation as, by reasonable inference, acquiesced to by Dr. Tu, and the fact that Ms. Norris-Pryzdia suffers significant difficulties which will simply worsen in the absence of proceeding with the surgery, the Arbitrator finds as a matter of fact and as a matter of law Respondent shall authorize and pay for the prospective medical treatment plus ancillary care and maintenance recommended by Dr. Daley in his evidence deposition.

Therefore, the Arbitrator finds as a matter of fact and a conclusion of law that Respondent shall authorize and pay for treatment that Petitioner undergoes at the hands of Dr. Daley or any additional physician that she may be referred to by Dr. Daley. In addition thereto, her benefits and rights under both Section 8(a) and Section 8(b) shall commence upon the time that the doctor determines that she is unable to continue in her current work activity.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

☒ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daiszenia J. Allotey (Williams),
Petitioner,

vs. NO: 06 WC 40169

14IWCC0320

Central Illinois Community Blood Center,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, permanent partial disability, medical expenses and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 8, 2013 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

14IWCC0320

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: MAY 0 1 2014

Daniel R. Donohoo

o-04/22/14
drd/wj
68

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALLOTEY (WILLIAMS) DAISZENIA J
Employee/Petitioner

Case# **06WC040169**
08WC033076

CENTRAL ILLINOIS COMMUNITY BLOOD CENTER
Employer/Respondent

14IWCC0320

On 3/8/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.12% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0834 KANOSKI & ASSOCIATES
CHARLES EDMISTON
129 S CONGRESS
RUSHVILLE, IL 62681

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
P O BOX 335
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Daiszenia J. Allotey (Williams)
Employee/Petitioner

v.

Central Illinois Community Blood Center
Employer/Respondent

Case # 06 WC 40169

Consolidated cases: 08 WC 33076

14IWCC0320

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Springfield**, on January 11, 2013. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☐ Other

14IWCC0320

FINDINGS

On **March 21, 2005**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$27,310.40**; the average weekly wage was **$525.20**.

On the date of accident, Petitioner was **50** years of age, ***single*** with **one** dependent child.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit for any medical bills it may have paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall be given a credit of **$5,652.42** in TTD, **$0** in TPD, **$0** in maintenance, **$0**in non-occupational indemnity disability benefits, and **$0** in other benefits for which a credit may be allowed under Section 8(j) of the Act, for a total credit of **$5,652.42.**

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $350.13/week for 15 1/7weeks, commencing 3/28/05 through 07/11/05, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services incurred by Petitioner with regard to her low back and mid-back complaints and treatment through July 11, 2005. Petitioner is not awarded any bills incurred by her in connection with the visit to Urgent Care on June 14, 2005. Respondent shall receive credit for any amounts paid by Respondent's sponsored health insurance and hold Petitioner harmless from any claims for reimbursement from said insurance as set forth in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $315.12/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Nancy Lindsay
Signature of Arbitrator

3.5.13
Date

MAR 0 2013

This is one of two cases that were consolidated for purposes of arbitration; however, the parties requested that separate decisions be issued.

The Arbitrator finds:

Petitioner testified that on March 21, 2005, she was working as a phlebotomist for Respondent. Petitioner testified that she was assisting a patient into a recliner. In doing so Petitioner was bearing the greater part of her weight and felt a pop in her back. Petitioner testified that she experienced the onset of low and upper back and neck pain at that time. Petitioner testified she was seen by Dr. Bansal that same day.

According to Dr. Bansal's records of March 21, 2005, Petitioner was transferring a donor to a recliner chair when she felt a pull in her right lower lumbar region. Petitioner's complaints included pain when bending forward and lifting. Petitioner denied any radiating leg pain, numbness, or tingling. Dr. Bansal noted palpable right lumbar tenderness and pain with motion of her back. Straight leg raise testing was negative bilaterally. Deep tendon reflexes were 2+ for Achilles and patellar. Dr. Bansal diagnosed Petitioner with a lumbar strain and prescribed medication and work restrictions of no lifting over 20 pounds. Petitioner was told to return on March 25, 2005. (PX 6, p. 1; RX 1)

As instructed, Petitioner returned on March 25, 2005, reporting no improvement in her symptoms. Petitioner also reported considerable low back pain with some radiation of pain down her left leg to her knee. Bending forward or sitting for any period of time was still aggravating Petitioner's pain. Dr. Bansal again noted palpable lumbar tenderness and pain with motion. He continued her medications and her 20 pound lifting restriction but added that she should avoid frequent bending, squatting or kneeling and that she was to sit, stand or walk as tolerated. Petitioner was to return on April 5, 2005. (PX 6, p. 2; RX 1)

Petitioner testified that she provided these restrictions to her employer but no work was offered within those restrictions, and she began receiving worker's compensation benefits. Petitioner testified that she also began therapy at Progressive Wellness at Dr. Bansal's direction on March 28, 2005. (PX 6, p. 8)

When initially evaluated at Progressive Wellness Center on the 28th Petitioner provided a history of transferring a blood donor from a wheelchair to another chair when she twisted her low back and heard and felt a popping sensation. Petitioner's chief complaint was increased pain bilaterally in her low back with radiating symptoms into her right thigh. Petitioner denied any numbness or tingling but reported increasing difficulty with her ability to sleep and sit. Petitioner was currently sleeping on her side and only able to sit for an hour at a time. Petitioner reported full function prior to her accident. With regard to her job as a phlebotomist, Petitioner reported she engaged in moderate lifting. Petitioner was to be seen three times at which time additional recommendations from her treating physician would be elicited. (PX 6, pp. 9-10; RX 2)

Petitioner returned to Dr. Bansal on April 5, 2005, reporting she was doing better but still having pain from her lower back to mid back region. Petitioner also reported that she could sit and stand for longer periods of time and denied radiating pain, numbness, or tingling at this time. She continued to have palpable lumbar tenderness on examination and pain with movement. Dr. Bansal continued her

restrictions and medications. Dr. Bansal's diagnosis remained the same. Petitioner was to return on April 18, 2005. (PX 6, p. 3; RX 1)

Dr. Bansal re-examined Petitioner on April 18, 2005, with Petitioner reporting that overall she was improving, though she had localized pain at the L1/2 area on the left which seemed to tighten up and made it uncomfortable to sit or stand for long periods of time. Petitioner denied radiating pain down her legs or numbness or tingling. Petitioner's diagnosis remained the same. Dr. Bansal recommended trigger point injections over Petitioner's left latissimus dorsi area and they were performed during the visit. He modified her lifting restriction to 25 pounds but continued the rest of her restrictions. (PX 6, p. 4; RX 1)

Petitioner returned again to Dr. Bansal on April 29, 2005, as instructed, reporting continued low back pain that was radiating. She had not improved and was having difficulty sitting or standing. She had palpable thoracolumbar tenderness into her mid back and pain with movement of the back. Dr. Bansal recommended that she obtain a lumbar MRI and continued her work restrictions. (PX 6, p. 5; RX 2)

A lumbar MRI was performed on May 3, 2005, which showed moderately severe spinal stenosis at L4/5 secondary to a central subligamentous disc herniation as well as facet arthropathy, and a mild concentric disc bulging at L5/S1. (PX 6, p. 6)

After the MRI, Petitioner returned to see Dr. Bansal on May 6, 2005, reporting continued low back pain and pain radiating in to her right leg to the knee. She reported that it was uncomfortable to sit and stand for any period. Dr. Bansal noted palpable tenderness on examination and pain with movement of the back. Dr. Bansal's diagnosis was changed to an L5/X1 disc bulge. Due to her continued symptoms, Dr. Bansal referred Petitioner to Dr. Smucker. Dr. Bansal continued her work restrictions. (PX 6, p. 7; RX 1)

Throughout the foregoing time period Petitioner continued to participate in physical therapy at Progressive Wellness Center. When noted, Petitioner's effort was described as maximum and her compliance as full. (PX 6, pp. 80 – 96) Petitioner attended physical therapy on the following dates: March 28; March 30; March 31; April 4; April 6; April 7; April 11; April 13; April 14; April 18; April 20; April 22, April 25; April 27; and April 29, 2005. The only "Patient Daily Note" which contains any reference to Petitioner's neck or shoulder region is the one dated April 27, 2005, in which Petitioner reported that her neck and shoulder region and mid-back were sore from the new exercises. Overall Petitioner reported her low back was feeling fine. (PX 6, pp. 80-96)

Petitioner was initially examined by Dr. Smucker on May 9, 2005, reporting a history of injury while assisting in the transfer of a donor and feeling her back pop at that time. (PX 5, p. 51) Petitioner reported seeing Dr. Bansal that very day and noting a "re-exacerbation" of her symptoms four days later at which time she was rechecked and given work restrictions which could not be accommodated. Petitioner described her treatment with Dr. Bansal and noted that her symptoms had eased somewhat with therapy but her low back pain radiating into her thighs persisted. She reported that she had pain and tingling not only through her low back but also up through her thoracic back to her neck, shoulders and arms. She reported that the low back symptoms were the worst. Petitioner reported that sitting would exacerbate her symptoms the most, but that bending and standing were also uncomfortable. On examination, Dr. Smucker noted some tenderness throughout the thoracolumbar para-midline region bilaterally. He reviewed the MRI and diagnosed Petitioner with lumbar degenerative disc disease with large subligamentous L4/5 disc herniation and resultant stenosis at that level, low back and thigh pain secondary to those findings and thoracolumbar complaints probably related to those findings, combined with soft tissue/myofascial pain. Dr. Smucker prescribed medication and an epidural steroid injection in

Petitioner's lumbar spine. He placed her on restrictions of no lifting over 25 pounds, sit/stand option and avoiding twisting or bending at the waist. He also directed Petitioner to resume therapy. (PX 5, pp. 51-53)

Petitioner underwent an epidural steroid injection at the L5 level on May 27, 2005, as well as continuing therapy at Progressive Wellness. (PX 5, pp. 44-49; PX 6, pp. 68-79)

Petitioner followed up with Dr. Smucker on June 1, 2005. Petitioner had stopped taking the Skelaxin and Mobic because she developed hoarseness and a sore throat. The lumbar epidural injection had resolved most of the pain radiating down into her legs; although, she still experienced fleeting radiating pain on occasion. Petitioner's low back pain was better but still ongoing, as was her thoracic pain. On examination, Petitioner had a negative neural tension sign on the right, equivocal on the left. There was no tenderness in palpating her low back but there was tenderness when palpating the thoracic back region on the left side. Dr. Smucker recommended a second injection, ongoing therapy, and continued work restrictions. (PX 5, p. 45)

Petitioner underwent a second injection on June 1, 2005. (PX 5)

Petitioner testified that the upper back, neck and arm pain that she described to Dr. Smucker had been present since the date of her accident, though Dr. Bansal had focused his treatment entirely on her low back, which had initially been a greater source of pain.

Petitioner presented to Springfield Clinic's Prompt Care on June 14, 2005 complaining of some neck swelling which started earlier in the evening. Petitioner described the location of the swelling as just above the collarbone in the area of her sternocleidomastoid area. She denied any pain. Petitioner reported that her muscles felt like they were straining as though she was holding something heavy. Petitioner denied any difficulty swallowing or breathing. She denied any radiating arm pain, numbness or weakness. Petitioner did report being treated for an ongoing back problem over the last three months and that she was currently undergoing physical therapy. Physical examination of Petitioner's neck revealed normal range of motion of her cervical spine without any pain. The attending doctor noted no edema, redness, swelling, or signs of infection. Petitioner displayed normal range of motion of her cervical spine without any pain. (RX 3) Cervical x-rays revealed no fracture, dislocation, or other acute anomaly. There was evidence of mild degenerative cervical spondylosis particarly at the C5-6 level with vertebral interspace narrowing and uncovertebral hypertrophy. (RX 3, p. 6) Dr. Campbell's assessment was swelling to the anterior neck, "not really appreciated on my exam." Petitioner was advised to continue her other medications and use ice a couple of times per day to help with the swelling. She should follow up with her doctor if no better or return to Prompt Care, as needed. (RX 3)

Petitioner presented to physical therapy on June 15, 2005, reporting that she had to go to Urgent Care on the 14th due to sharp pain in her neck in between her shoulder blades. Petitioner also reported a major increase in swelling in her neck/shoulder region. Petitioner was instructed to call her doctor immediately. Petitioner tolerated her treatment well without increased complaints of pain. No traction or new exercises were added due to her neck symptoms. (PX 6, p. 69)

Petitioner returned to Dr. Smucker's office on June 17, 2005, in a visit described as "urgent." Petitioner was complaining of swelling and pain in her neck, shoulder girdle, and extending into the bilateral upper extremities with radiating parasthesia. She reported that her low back and leg symptoms had quieted down some. Though Dr. Smucker did not observe swelling he indicated that a therapist had called and

reported seeing swelling. He noted that cervicothoracic complaints had been present to various degrees since the reported injury and that her current symptoms suggested myofascial pain. Dr. Smucker noted that Petitioner's cervicothoracic complaints had been present to various degrees since the reported injury. The current intense pain Petitioner described was suggestive of cervicothoracic myofascial pain. He recommended an EMG/NCV to check for radiculopathy or neuropathy. He continued Petitioner's work restrictions, noting that Respondent had been unable to accommodate them so far. (PX 5, pp. 42-43)

Petitioner presented to physical therapy later in the day on the 17th. According to the daily note, Petitioner had just been seen by Dr. Smucker and was to undergo a test on her neck. Petitioner reported she had to leave early that day because she had an appointment scheduled with her primary care physician. Petitioner reported soreness n her low back. Petitioner did not complete all of her exercises due to her need to leave early. (PX 6, p. 68)

Petitioner underwent another therapy session on June 20, 2005. She described her low back pain as 1-2/10 and her upper back/shoulder pain as 4/10. Petitioner was still waiting for authorization to proceed with the EMG testing recommended by Dr. Smucker. (PX 6, p. 67)

Petitioner was seen at the Memorial Medical Center emergency room on June 21, 2005, reporting a history of a back injury on March 21, 2005. Petitioner had been evaluated by her family physician and Dr. Smucker and was initially started on Skelaxin and Mobic but was feeling "strange" and five days ago was switched to phenoprofen and amitryptiline. Petitioner reported persistent pain over her shoulder blades unrelieved by any medication. Petitioner described pain in her back and up to her neck, with swelling in her neck and pain across her shoulders and radiating into her left arm. (PX 7, pp. 7, 10) Petitioner was prescribed Decadron and Tramadol for pain. (PX 7, p. 8)

Petitioner testified at the Arbitration hearing that this was the same pain she had been experiencing since her work accident, though it had become more intense without any new accident or injury.

Petitioner underwent physical therapy from June 24, 2005 through July 7, 2005. During this time Petitioner repeatedly reported that the swelling she was experiencing in her neck was due to the steroids she had been taking. (PX 6, pp. 64, 62) As of July 7, 2005, the therapist noted that Petitioner was reporting 85% improvement in her low back pain overall. Petitioner continued to note severe pain in her upper back into her left upper extremity with numbness and tingling; however, she was improving. Petitioner was discharged to a home program for her back. The doctor was asked to advise if anything more was to be done for Petitioner's neck. (PX 6, pp. 58-59; PX 5, p. 39)

Petitioner testified that she was sent to Dr. Orth in Chicago by the worker's compensation insurance carrier for an examination on July 11, 2005. Petitioner testified that her TTD benefits ended as a result of that examination when Dr. Orth released her to work without restrictions. Petitioner testified that she did not return to work as Dr. Smucker still had prescribed work restrictions which her employer would not honor. Petitioner testified that her employer terminated her shortly after Dr. Orth's release.

In his report, Dr. Orth opined that Petitioner was at maximum medical improvement as a result of her low back injury but that she also needed additional work-up for her suprascapular complaints that were beyond his area of expertise. During his physical examination of Petitioner he did note swelling in the suprascapular area but he did not believe it was causally related to her 2003 work accident due to the lack of cervical complaints noted in her records early on. (RX 4, dep. ex.)

Petitioner returned to see Dr. Smucker on July 27, 2005, at which time the doctor noted that the EMG/NCV study had been denied by the insurance carrier. He further noted that the insurance company had obtained an IME that indicated that Petitioner could return to full duty work. Petitioner continued to complain of cervical and upper thoracic pain with pain and paresthesia radiation into the upper extremities, left greater than right. Examination revealed a diminished biceps reflex on the left. Dr. Smucker's impression was lumbar degenerative disc disease with lower extremity symptoms improved with two epidural steroid injections and cervicothoracic complaints with upper extremity paresthesia and diminished left biceps reflex, suggesting a C5 or C6 radiculopathy. He continued to recommend the EMG/NCV as well as a cervical MRI. He provided work restrictions of no lifting over 25 pounds and no overhead work. He also recommended physical therapy 3 times per week. (PX 5, p. 38)

Petitioner underwent a Physical Therapy Initial Evaluation on August 2, 2005. According to the history, Petitioner reported a March 21, 2005 accident when she was transferring a patient from one wheelchair to another and she felt a pop and severe pain in her low back. She was treated with physical therapy and her low back pain was steadily improving. The history then states,

> However, she reports that on 6/15, while standing, she noted a sharp pain in between her shoulders [sic] blades extending up into the back of her neck. She states that later her neck and shoulders became very swollen, leading her to seek treatment at Prompt Care.
> (PX 5, p. 34)

Petitioner reported that her neck pain had continued to worsen while her low back pain had improved. Petitioner's primary complaint was mid-back and neck pain extending up into the back of her head and throughout both arms. Petitioner also reported "stinging at right arm" and "tingling and burning" at her left hand, along with giving away. Petitioner's lower extremity pain had resolved but some low back pain spasms continued. Petitioner's cervical movements were described as "guarded." No edema or ecchymosis was visualized. Petitioner was to be seen two to three times per week for 3 -4 weeks, initially. (PX 5, p. 34-36)

An MRI of Petitioner's cervical spine was obtained on August 6, 2005, showing degenerative disc and endplate osteophytic changes on the right at C3/4 and C5/6 with right greater than left foraminal narrowing at those levels. An MRI of Petitioner's thoracic spine showed minimal bulges present in the mid thoracic spine at T2/3, 3/4 and 4/5 with no cord impingement. The radiologist concluded that the scan was "essentially unremarkable". (PX 5, pp. 29-30) Petitioner underwent EMG/NCV testing by Dr. Smucker on August 19, 2005 that showed a mild C6 radiculopathy and no evidence of any peripheral neuropathies. (PX 5, pp. 24-28)

Petitioner's Progress Note from Progressive Wellness Center dated August 24, 2005 stated Petitioner had given maximum effort and full compliance during the reporting period. Petitioner was not responding well to physical therapy at that time as Petitioner was noting increased pain in her cervical spine and low back which she rated a 6-7/10. Despite attempts with distraction and myofascial techniques, Petitioner was unable to tolerate the therapy. She was noted to be performing a pain-free exercise program. (PX 5, p. 23)

Petitioner returned to Dr. Smucker on August 26, 2005. He noted that Petitioner continued to complain of cervical and thoracic pain and pressure as well as paresthesia into both upper extremities. He noted she had work restrictions but had been terminated from her job. On physical examination, Dr. Smucker noted a decreased left biceps reflex. He noted that the cervical MRI had shown disc-osteophyte complexes at C3/4 and C5/6. He continued her work restrictions and recommended cervical epidural steroid injections. Petitioner was not taking any medications. (PX 5, p. 21)

Petitioner had a left C7/T1 epidural steroid injection on September 12, 2005. (PX 5, p. 19)

Petitioner's September 23, 2005 Progress Note from physical therapy indicated Petitioner was noting temporary improvement in her neck pain as a result of physical therapy. "Very minimal objective" improvement in cervical range of motion was noted. Petitioner was scheduled for another injection in the upcoming week. (PX 5, p. 18))

Dr. Smucker re-examined Petitioner on October 7, 2005. Dr. Smucker noted that Petitioner had experienced no improvement with the first injection so the second planned injection was cancelled. He further noted she had been set up for an appointment to see Dr. VanFleet. Physical therapy was to be continued. She was placed back on Tizanidine, which helps her sleep at night. Petitioner's ongoing complaints included pain in her neck and trapezius areas and into both arms to the fingers, especially the index and middle fingers of the hands. He noted that her symptoms were initially on the left side and were now on both sides. His impression was cervical radiculopathy and cervical degenerative disc disease with osteophyte complexes as noted and some flattening of the cord. Petitioner's work restrictions were continued but her physical therapy sessions were decreased. (PX 5, p. 17)

As of October 6, 2005, Petitioner was reporting significant temporary relief of pain with her physical therapy treatments. However, with any increased activity level, her pain would return. Petitioner had progressed in her therapy, however. (PX 5, p. 14)

Dr. Timothy VanFleet examined Petitioner at Dr. Smucker's request on October 19, 2005. In connection with the examination, Petitioner completed a "Spine Sheet." Petitioner's primary problem was listed as pain and swelling in the cervical area and periodic low back pain. Petitioner stated that her first episode of pain began on March 21, 2005 as a result of an injury/accident. She listed "March 21, 2005" as the date of accident and identified her "Back" as the part of the body she injured. Petitioner denied any prior back or neck trouble. Petitioner described the accident as follows:

> 3-21-05 I was working at Central IL Comm. Bld Cntr.
> Donor had bad reaction. I helped transfer donor from
> w/c to recliner. I lifted upper body during transfer,
> back popped very hard. Pain started in my lower back
> radiated down left leg. Also had pain in upper back.
> Pain increased in upper back 6.15.05."
> (PX 5, p. 4)

Petitioner further stated that her most recent episode had started on June 15, 2005 and she went to the emergency room. Petitioner provided additional information concerning the nature of her pain, its location on a pain drawing, and its severity (7/10). (PX 5, pp. 4-7)

When examined by Dr. VanFleet, Petitioner's complaints included difficulty with neck pain and bilateral radiating arm pain. Petitioner had evidence of multilevel cervical degenerative disc disease without any evidence of focal neurologic compression. He did not feel she was a surgical candidate at the present time as he didn't believe her symptoms would respond well to an operation. He emphasized the importance of continued non-operative care with a structured physical therapy program. Petitioner provided a consistent history of her initial accident with a pop in her back and pain in her back and leg as well as neck pain. She reported that her symptoms in her back and leg were intermittent and of lesser concern. These had responded well to injections. She described pain and swelling in her interscapular area and paresthesias in her upper extremities. Dr. Van Fleet felt that Petitioner was suffering from multilevel degenerative disc disease but did not feel that she was a surgical candidate. He recommended that she continue with active stretching and exercise. (PX 5, pp. 11–13)

Petitioner saw Dr. Smucker on the same date. He noted Dr. Van Fleet's conclusions. Petitioner reported to him that she had been terminated from her job and she was planning to return to Peoria, Illinois and seek work there. Dr. Smucker released Petitioner to full duty, full-time work, and stated "I feel that we have done everything that I know to do to try and help and therefore, I consider her to have achieved maximum medical improvement." She was to continue Tizanidine at bedtime. (PX 5, p. 10)

Petitioner telephoned the physical therapist on October 20, 2005, to notify Progressive that she was cancelling the remainder of her appointments as she was moving out of town and had been released by her doctor. (PX 6, p. 27)

Petitioner testified that she continued to experience pain in her low back, upper back and neck after her release by Dr. VanFleet. Petitioner changed jobs on November 22, 2005, going to work for the American Red Cross in Peoria, Illinois. Petitioner testified that this job involved attending blood drives and moving equipment associated with those drives.

Petitioner testified that on or about August 15, 2006, while attending a blood drive in Galesburg, Illinois, she was moving a piece of heavy equipment that was on wheels up a ramp onto a lift of a truck. As the equipment was being moved it started to roll and she reached out and grabbed it and pulled it back onto the truck's platform, resulting in a sudden increase in her lower and upper back and neck pain. Petitioner testified that she filled out paperwork with the American Red Cross to report this incident as a workers' compensation case. Petitioner testified that she had consulted with an attorney about this incident and had completed paperwork to be sure that proper notice was given within the 45 day statutory period.

Petitioner filed her Application for Adjustment of Claim against Respondent on September 15, 2006. Petitioner claimed she was transferring a patient on March 21, 2005 when she injured her back and neck. (AX 2)

Petitioner underwent no medical treatment between October 19, 2005 and September 21, 2006.

On September 21, 2006, Petitioner presented to Dr. Richard Kube at the Midwest Orthopedic Center in Peoria, complaining of upper back and neck pain. (PX 1, p. 310) Petitioner testified that this was the earliest appointment that she was able to obtain after her August 15, 2006 accident. Petitioner completed a New Patient Intake Form at the time of the visit. She gave an onset date of March 21, 2005. There is no mention of an accident on August 15, 2006 (RX 3) According to the records Petitioner had been having some problems with upper back and neck pain for about a year and that the problems began

when she was moving a patient at her former job with Respondent. Petitioner reported she was now working for the Red Cross and continuing to have some problems. Petitioner expressed concern that she might lose her job. "This is a litigious issue work comp claim from previous." At this time Petitioner was working as phlebotomist for the American Red Cross. Petitioner was noted to be married, but living alone. On examination, Dr. Kube noted that Petitioner walked with an antalgic gait, but did not have signs of myelopathy. He noted that she had pain in her back with a right-sided Spurling's maneuver. He noted that she had some point tenderness in her upper thoracic spine at mid line. X-rays on that date showed diffuse degenerative change in her thoracic and cervical spine. She showed some cervical spondylosis at C3/4 and C5/6. He recommended physical therapy and an MRI and noted that steroid injections may be required. An MRI was taken on September 25, 2006, and showed multi-level degenerative changes in Petitioner's cervical spine, worse at the C3/4 and C5/6 levels. (PX 1, pp. 306-307) It was noted that there was moderate proximal right neuroforaminal stenosis at C3/4, and moderate to severe right neuroforaminal stenosis at C5/6. (PX 1)

Petitioner underwent an initial physical therapy evaluation at the Midwest Orthopedic Center on September 26, 2006. Petitioner's presenting diagnoses included cervicalgia, joint stiffness in the neck, and muscle weakness. She reported that her recent problem had started while at work as a phlebotomist when she was pushing something heavy and heard a pop in her low back. She reported that pain was now radiating into her upper back and neck and that the problem had been aggravated by her new job as phlebotomist for the Red Cross pushing and lifting heavy objects. Petitioner wished to get the pain under control and avoid surgery. Petitioner was tearful during the evaluation, worried about losing her job, undergoing a divorce, and living with her granddaughter who she took care of. Petitioner sated "she noticed the pain started at the same the major life changes of the move and the separation from her husband took place." Her doctor tried to medicate her for depression but she declined noting she could not tolerate the medication due to her sensitivity to medicine. (PX 1, pp. 303-304)

Petitioner returned to Dr. Kube on October 16, 2006, who noted the MRI results. He recommended another round of steroid injections to see if that would help alleviate her nerve pain, and also recommended an EMG to localize the source of her pain. (PX 1, p. 299)

An EMG was done on October 24, 2006 by Dr. Yibing Li finding bilateral mild carpal tunnel syndrome and bilateral ulnar neuropathy at the wrists. (PX 1, pp. 293-297) He noted that there were some findings suggesting early or mild cervical radiculopathy bilaterally at C5/6 and C6/7 but the findings were not definitive.

At the request of Dr. Kube, Petitioner was seen by Dr. Demaceo Howard on October 26, 2006. Dr. Howard recorded a history of "persistent pain following a work-related injury in which her low back was involved." Petitioner had been treated with both lumbar epidural steroid injection and cervical injections. Petitioner reported improvement with the injections in her low back but not her neck. He noted that she has continued gainful employment without any significant interruption and noted that the recent EMG findings that did not explain her ongoing pain. Dr. Howard performed a physical examination. He concluded that Petitioner was suffering from non-radicular neck pain with evidence of disc degeneration and facet arthropathy and bone spur complex. He felt that she was suffering from possible facet arthropathy or discogenic neck pain. He planned to proceed with a medial branch block. (PX 1, pp. 290-291)

Petitioner underwent medial branch blocks at the C3,4 and 5 levels on December 7, 2006 on the right and on December 15, 2006 on the left at the Methodist Medical Center. (PX 4, pp. 9, 38) Petitioner returned to Dr. Howard on January 3, 2007, reporting that her neck pain was about 50% better, but still present. (PX 1, p. 260) Dr. Howard recommended conservative treatment with Ultram and Skelaxin and directed Petitioner to follow up on an as-needed basis.

Petitioner returned to Dr. Kube on January 18, 2007, reporting continued pain in her neck and shoulders. (PX 1, p. 248) She also reported some occasional pain in her right upper extremity. She denied any really significant relief from the injections in her neck. Based upon her MRI and EMG findings, Dr. Kube stated that he did not think that there was a surgical intervention that would relieve her symptoms at that point, and released her from care to return as needed.

Petitioner testified that she continued working and continued to experience the same pain in her neck that she had experienced since her initial accident. Petitioner underwent no treatment between January 18, 2007 and September 21, 2007.

On September 21, 2007, Petitioner was examined by Dr. John Mahoney due to complaints of right wrist pain that had been present for the past 6 to 8 weeks. (PX 1, pp. 240-241) As part of the examination Petitioner completed a Medical History Questionnaire (PX 1, pp. 244 – 245) In that Questionnaire, Petitioner listed her chief complaint as pain in her right wrist and thumb which had started six weeks earlier. Petitioner listed her employer as the American Red Cross. She denied having injured herself on the job.

Dr. Mahoney noted that Petitioner had previously been seen by Dr. Kube for complaints of neck pain that "seems to be a different problem." Her biggest problem was reportedly radial-sided wrist and thumb pain. (PX 1, p. 240) Dr. Mahoney believed Petitioner had right De Quervain's tenosynovitis and he recommended a steroid injection which Petitioner underwent that same day. Petitioner followed up with the doctor on October 19, 2007 at which time Petitioner reported the injection had helped a lot but she was not completely cured. Petitioner denied any numbness or tingling in her hand. (PX 1, p. 239) Petitioner testified that she pursued treatment through Dr. Mahoney for treatment of her hands, which is the subject of another claim not now before the Arbitrator.

Petitioner returned to see Dr. Mahoney on January 15, 2008. At that time he diagnosed Petitioner with recurrent right wrist DeQuervain's tenosynovitis and bilateral carpal tunnel syndrome with superimposed cervical radiculopathy. (PX 1, pp. 236-237) Dr. Mahoney injected the first dorsal compartment of Petitioner's right wrist and the carpal tunnel of Petitioner's left wrist. Dr. Mahoney also referred Petitioner to Dr. Mulconrey to assist him in determining how much of her symptoms were coming from her neck versus how much was coming from the median nerve compression in her carpal tunnel.

When Petitioner returned to Dr. Mahoney on January 29, 2008, she reported that the DeQuervain's injection had helped a little but that the carpal tunnel injection to the left wrist had not helped much. She still complained of tingling in her median nerve digits bilaterally. She also reported some pain radiating down from her neck into her shoulders as well. He opined that's he may benefit from surgery on her DeQuervain's, and that she may be suffering from a double crush effect with both her neck and carpal tunnel compressions contributing to the numbness and tingling in her fingers. She was to see Dr. Mulconrey in the next couple of weeks. (PX 1, p. 235)

Petitioner eventually saw Dr. Mulconrey on February 11, 2008, over one year after her visit with Dr. Mahoney. (PX 1, pp. 232-233) His history noted that she had been involved in a work accident in June of 2005 with recurrent problems since that time. She reported axial neck pain rated at 4.2/10 and upper extremity pain at 6/10. Her pain was worse in her right arm than her left. She reported pain in her bilateral trapezial region, right shoulder, upper arm and both hands. Raising her arm would worsen her pain. She also reported weakness in her right hand and intermittent paresthesia in the lateral three digits bilaterally. She reported occasional headaches that were moderate but frequent. On examination, he noted decreased sensation in her bilateral lateral forearms, and decreased strength on the right in her biceps, triceps, wrist flexors and extensors when compared to the left. X-rays showed bilateral uncinate spurring at C5/6, mild degenerative disc disease at C3/4 and mild uncinate spurring on the left at C6/7. Dr. Mulconrey diagnosed multilevel cervical spondylosis, degenerative disc disease and bilateral upper extremity radiculopathy. He opined that Petitioner had foraminal stenosis with radicular symptoms that was causing her decreased sensation and strength. He ordered an MRI of her cervical spine which was done on February 14, 2008 and showed multilevel spondylosis C3 through C6 with uncinate spurring and disc bulging, and borderline central stenosis at all three levels. (PX 1, p. 215) Foraminal narrowing was also present, worse at C5/6 and C3/4. There was also a left paramedian protrusion at C6/7.

Petitioner returned to Dr. Mulconrey on March 21, 2008. (PX 1, p. 213) He reviewed the MRI results and recommended an anterior cervical decompression and fusion. He noted that she had experienced some relief with the previous injections by Dr. Howard. (PX 1, p. 212) He felt that the pain that Petitioner was experiencing in the right hand was related to problems at C5/6. Dr. Mulconrey saw Petitioner back for a pre-operative review of the procedure on May 7, 2008, (PX 1, p. 200) and then proceeded with surgery on May 27, 2008 at OSF St Francis consisting of an anterior cervical decompression and fusion at C5/6. (PX 2, pp. 6-7)

Petitioner followed up with Dr. Mulconrey on June 16, 2008, reporting some difficulty swallowing after surgery that was improving. (PX 1, p. 196) Dr. Mulconrey noted that she was to remain off work and directed her to start physical therapy. Petitioner returned on July 23, 2008, and was noted to be doing well overall, but was still complaining of interscapular pain which Dr. Mulconrey expected to improve as her fusion solidified. (PX 1, p. 194) She also complained of continued intermittent upper extremity radiculopathy, and complained that she was having occasional problems with her voice. Dr. Mulconrey noted that her problems with her voice could be related to her cervical surgery, but that he anticipated they would improve. Petitioner returned to Dr. Mulconrey again on August 27, 2008, reporting improvement in her interscapular pain, but complained of swelling on the left anterior portion of her neck in the supraclavicular area. (PX 1, p. 103) She also reported improvement in her voice and Dr. Mulconrey noted that a laryngoscopy had been done by an ENT and found no evidence of vocal cord paralysis. (See PX 3, pp. 81-86) She was given a 25 pound lifting restriction and advised to return in three months. However, Petitioner testified that, at her urging, the Dr. Mulconrey released her without restrictions at that time so that she could return to work.

Petitioner returned to Dr. Mulconrey on November 19, 2008, overall doing well, but reporting a recent increase in her mid-scapular pain. (PX 1, p. 100) Her upper extremity radiculopathy had nearly resolved. X-rays indicated that instrumentation was in appropriate position, but that the superior portion of the graft was not yet completely healed. Dr. Mulconrey continued her Neurontin and directed her to return for a one-year follow-up. Petitioner returned on May 20, 2009, reporting that she was doing well overall but was having intermittent pain in her cervical spine. (PX 1, p. 92) X-rays showed proper positioning but there was some question as to whether the upper end plate had completely fused. Dr.

Mulconrey prescribed Flexeril, a Medrol dose pack as well as Naprosyn. He noted that she was having considerable lumbar based symptoms that might require therapy.

Petitioner filed an Application for Adjustment of Claim against the American Red Cross on July 28, 2008 (case # 08 WC 33076) Petitioner alleged she injured her neck on August 15, 2006 while "pushing." (AX 4)

Petitioner underwent no treatment between November 19, 2008 and April 25, 2011.

Petitioner returned again to Dr. Mulconrey on April 25, 2011, three years following her cervical fusion. (PX 1, p. 49) Petitioner reported that she continued to suffer axial neck spasms but no significant upper extremity pain or symptoms. Petitioner did, however, describe significant low back pain, with symptoms in her lumbar spine and bilateral buttocks. Petitioner reported having difficulty at work and a recent incident where she had bent over and had difficulty straightening back up. On examination, Petitioner had some limitation in lumbar extension and a mildly positive straight leg raising test. Dr. Mulconrey diagnosed spondylolisthesis by x-ray examination, spinal stenosis and lumbar spondylosis. He prescribed physical therapy, injections by Dr. Sureka and Neurontin and Naprosyn. (PX 1, p. 49)

Petitioner saw Dr. Sureka on the following day, April 26, 2011, reporting a six year history of low back and right leg pain. (PX 1, pp. 46-47) She reported that the pain traveled along the right anterior thigh and was worse with walking or bending. Dr. Sureka diagnosed possible lumbar radicular pain with low back and leg pain and recommended an MRI of her lumbar spine and physical therapy. Records show that Petitioner began a course of physical therapy on April 29, 2011. (PX 1, pp. 43-44) The MRI performed on May 2, 2011, showed anterolisthesis at L4/5 with moderate central canal stenosis in combination with facet arthropathy and ligamentum flavum hypertrophy. It also showed a broad based disc protrusion at L3/4 with moderate neural foraminal narrowing and impingement of the exiting nerve at L3. (PX 1, pp. 63-64)

Petitioner returned to Dr. Sureka on May 4, 2011, reporting that her buttock and leg pain had improved but her low back pain remained the same, and was exacerbated by bending or prolonged walking. (PX 1, p. 41) After reviewing the MRI, Dr. Sureka recommended a course of right L4 transforaminal epidural steroid injections, Gabapentin and continued therapy. Petitioner did undergo epidural steroid injections on June 1, 2011 (Left L5), June 8, 2011 (Right L4) and June 22, 2011 (Left L5). (PX 1, pp. 65-68) Petitioner returned to Dr. Sureka on July 13, 2011, reporting that the third epidural steroid injection did not give significant relief. (PX 1, p. 13) She reported cramping pain in her leg and continued low back pain. She reported that bending, standing and walking tended to worsen her pain. Dr. Sureka recommended a bone scan and use of Cyclogenzaprine three times daily for symptom relief. (PX 1, p. 13) A bone scan was done on July 18, 2011, but did not reveal significant abnormalities other than "mild facet osteoarthritic osteoblastic activity in the lower lumbar region at L3 to S1". (PX 1, p. 75) Dr. Sureka's office recommended referral to a surgeon (PX 1, p. 11) but the suggestion was not pursued at that time as Petitioner was beginning a new job. (PX 1, p. 10)

Petitioner offered the evidence deposition of Dr. Daniel Mulconrey, an orthopedic spine surgeon taken on March 29, 2010. Dr. Mulconrey testified that since he saw Petitioner some time after her accidents had occurred he had difficulty relating specific findings on the MRIs to her work accidents, as they could be either acute or chronic changes. (PX 10, pp. 16-17) However, he testified that a tugging or pulling type of injury can aggravate these conditions in the cervical spine. (PX 10, p. 18) He testified that such conditions could be aggravated by accidents without significant changes on the MRI. (PX 10, p. 19) He also testified that findings as he had found on the MRIs could be present without symptoms. (PX 10, p.

20) He testified that if a patient with such changes is symptom free and then develops symptoms in connection with a work accident, those accidents would be considered contributing causes for her need for surgery. (PX 10, p. 21) He testified that based upon a hypothetical question describing both work accidents, it would be difficult, if not impossible, to separate the two and give an opinion as to the relative contribution of each accident to her condition. (PX 10, p. 21) Dr. Mulconrey acknowledged having given Petitioner off work slips dated June 16, 2008 and July 23, 2008, the latter keeping her off work until her next appointment in 4 or 5 weeks. (PX 10, p. 23, Pet Depo Ex. 2 and 3).

On cross-examination by counsel for the American Red Cross, Dr. Mulconrey testified that Petitioner's complaints and pain diagram that Petitioner provided initially to Dr. Van Fleet on October 16, 2005, could be consistent with the findings that he observed on the MRI in 2008. (PX 10, p. 28) He also testified that the pain diagram that Petitioner completed for Dr. Kube when Petitioner saw him on September 21, 2006, could be consistent with the condition for which the he performed surgery on May 27, 2008, though the pain diagram was different than the one completed for Dr. Van Fleet. (PX 10, p. 29) Dr. Mulconrey testified that the findings on the MRI dated September 25, 2006 could be present absent any traumatic event. (PX 10, p. 32) He testified that he could not determine the age of the findings without seeing pervious MRI studies, though the finding of a right paracentral disc protrusion could possibly be an acute finding. (PX 10, p.33) Based upon a review of records presented to him by the attorney for American Red Cross, Dr. Mulconrey testified that the symptoms that Petitioner described to him appeared to relate to the March 2005 incident. (PX 10, p. 39) Based upon those records, he opined that the surgery that he performed could have been required absent any other inciting factor beyond that initial incident in March 2005. (PX 10, pp. 39-40) Dr. Mulconrey testified under cross-examination by Central Illinois Blood Bank's attorney that comparing the MRI that he had performed in 2008 and the report of the MRI done in 2006 it appeared that the findings were similar. (PX 10, p. 50)

Respondent offered the deposition of Dr. Michael Orth who examined Petitioner pursuant to Section 12 of the Illinois Workers Compensation Act on July 8, 2005. Dr. Orth claimed in his report and deposition testimony that Petitioner indicated to him that her neck pain began on June 15, 2005. (See RX 4, p. 7) He opined that Petitioner had suffered an acute lumbosacral strain at the time of her first work injury that was superimposed upon a pre-existing degenerative arthritis with spinal stenosis at L4/5. (RX 4, p. 9) Dr. Ortho opined that her low back condition had reached maximum medical improvement by the time of his examination. (RX 4, p. 10) Dr. Orth testified that Petitioner had a normal examination regarding her cervical region though she had an unidentified condition in her supraclavicular area. (RX 4, p. 10-11) Dr. Orth stated that Petitioner had some tenderness in the paraspinal muscle mass, the trapezius and upper half of the thoracic paraspinal musculature. (RX 4, p. 13) Dr. Orth opined that the complaints that Petitioner had in her cervical area and supraclavicular area were not related to her work accident in March of 2005. (RX 4, p. 14) Dr. Orth admitted on cross-examination that if he accepted the history to Dr. Smucker of cervical and thoracic complaints since the reported injury, he would have to relate those complaints to the accident. (RX 4, pp. 16-17) He also acknowledged that the type of accident that she described in lifting a patient would be consistent with an injury that would cause such cervical complaints. (RX 4, p. 17) He also acknowledged that his findings of cervical paraspinal muscle mass tenderness were consistent with a problem in the cervical spine. (RX 4, p. 17) Dr. Orth testified that his current practice is limited to doing independent medical evaluations and that he had retired from clinical practice in December 2004. (RX 4, p. 18) He testified that his examinations are nearly 100% at the request of respondents. (RX 4, p. 19) Dr. Orth testified that when he was in active orthopedic practice, he did not do neck surgery. (RX 4, p. 19) Upon further cross-examination, Dr. Orth acknowledged that Petitioner was off work at the time of his examination and he did not release her to return to work. (RX

4, p. 26) He acknowledged that Petitioner had complaints of numbness in her hands and tingling sensations that could be an abnormality associated with one of the cervical nerve roots. (RX 4, pp. 23-24)

Respondent American Red Cross offered the deposition of Dr. Marshall Matz taken on May 26, 2010. Dr. Matz testified that Petitioner had reported to him that she injured her back on August 15, 2006, near the end of her work day as a phlebotomist, she was loading a piece of equipment onto a vehicle when the equipment started to roll backwards and she attempted to stop it and injured her back. (RX 7, p. 7-8) He stated that he asked Petitioner whether she had any prior treatment to her back or spine and she denied any similar conditions or complaints in the past. (RX 7, p. 8) Dr. Matz testified that medical records contradicted this statement, showing "a variety of spinal complaints and specifically complaints involving her neck and limbs" going back to early 2005. (RX 7, p. 8) He confirmed that an injury date of May 21, 2005 contained in his report may be a typographical error. (RX 7, p. 8-9) Dr. Matz testified that records of Dr. Bansal dated April 29, 2005 and of the Orthopedic Center of Illinois dated May 9, 2005 show spinal complaints. (RX 7, pp. 9-10) He testified that complaints reflected in the office note of June 17, 2005, from the Orthopedic Center of Illinois were consistent with cervical radiculopathy preceding her accident at American Red Cross. (RX 7, p. 10) Dr. Matz testified that complaints at the Orthopedic Center of Illinois on July 27, 2005, of radiating paresthesia and diminished biceps reflex would be consistent with some nerve root irritation of the C5/6 level pre-dating Petitioner's accident at American Red Cross. Dr. Matz noted that a history in a physical therapy note of August 2, 2005, of the onset of pain between the shoulder blades on June 15, 2005 that extended to her neck followed by swelling in the neck and shoulder could refer to referred pain from the neck. (RX 7, p. 12) Dr. Matz testified that decreased cervical range of motion and strength, with stinging pain in the right arm and tingling down the left described in that note could be consistent with cervical radiculitis. (RX 7, p. 12) Dr. Matz testified that complaints of pain in the neck, trapezius and both arms noted in an Orthopedic Center of Illinois note of October 7, 2005 show further pre-existing symptoms. (R X 7, p. 13) In reviewing findings on a cervical MRI of August 6, 2005, Dr. Matz testified that the findings on C3/4 to the right were an incidental finding, but that findings at C5/6 with left foraminal narrowing could be the source of Petitioner's neck and arm complaints. (RX 7, pp. 13-14) Dr. Matz testified that findings on an EMG of August 19, 2005 demonstrated a C6 radiculopathy that pre-existed her accident at American Red Cross, and was consistent with her prior reference to a diminished reflex. (RX 7, p. 14) Dr. Matz testified that the Orthopedic Center of Illinois note of August 26, 2005, showing complaints of cervical and thoracic pain and pressure and paresthesia in the bilateral upper extremities were further evidence of a pre-existing chronic condition. (RX 7, pp. 14-15) Dr. Matz noted that the initial treatment note of Dr. Kube on September 21, 2006, after Petitioner's accident of August 15, 2006, referred to neck and upper back pain that had been present for about a year and started while moving a patient at a former job, and did not refer to any new accident. (RX 7, p. 15-16) He reviewed the intake note for that appointment, noting that it referred to an accident date of March 21, 2005 and that her complaints had been going on for a year. (RX 7, pp. 16-17) Dr. Matz testified that he reviewed the film of the MRI of September 25, 2006, and testified that there was no significant change from the prior film and that he did not feel that it showed any acute findings. (RX 7, p. 17) Dr. Matz also testified that he had reviewed a record of Dr. Howard dated October 26, 2006, and noted that there was no history of an August 15, 2006 occurrence. (RX 7, p. 19) Dr. Matz was also directed to the office note of Dr. Mulconrey of February 11, 2008, and noted that the history referring to an accident in June 2005, referred to long standing issues long pre-dating August 2006. (RX 7, p. 19) He confirmed that her complaints at that time were similar to those voiced in 2005. (RX 7, p. 19) Dr. Matz's attention was also directed to the history form completed at the time of the February 11, 2008 visit with Dr. Mulconrey referring to neck pain and that had been present since June 2005, and testified that this was also consistent with long standing pre-existing complaints. (RX 7, p. 20) Dr. Matz testified that the radiology findings of the MRI taken on February 14, 2008, were similar to the

MRI findings in 2005 and testified that there were no acute findings on that scan that would be attributed to the incident of August 25, 2006. (RX 7, pp. 20-21) Dr. Matz testified that in his opinion there was no causal connection between Petitioner's work-related accident of August 15, 2006, and her treatment starting with Dr. Kube on September 21, 2006 and subsequent surgical intervention on May 27, 2008. (RX 7, p. 24)

On cross-examination, Dr. Matz confirmed that the degenerative conditions as found in Petitioner's spine can be aggravated by incidents of lifting or pulling heavy objects as she described, where a history relates no prior symptoms and a sudden onset of symptoms related to the incident. (RX 7, p. 30) Dr. Matz acknowledged that some patients with such MRI findings would not have symptoms and that surgery would be performed only associated with symptoms that affect the patient's quality of life. (RX 7, pp. 31-32) Dr. Matz testified that he has not done surgeries for five years and that currently 30 percent of his practice is related to performing medical-legal examinations. (RX 7, pp. 33-34) He testified that he does a couple of exams per month for Respondent's counsel's firm. (RX 7, pp. 34-35)

Petitioner also offered the evidence deposition of Dr. Paul Smucker taken on March 3, 2011. Dr. Smucker testified that when he initially saw Petitioner on May 9, 2005, she was reporting pain, not only in her low back, but also pain and tingling radiating up the thoracic back and into the neck, shoulder and arms. (PX 9, p. 6) Her primary complaint at the initial visit was of the pain in her low and mid back. (PX 9, p. 6) Following examination, Dr. Smucker diagnosed lumbar degenerative disc disease with a large broad based midline L4/5 disc herniation causing stenosis. He felt that the low back and thigh pain was related to that herniation. He also felt she had some soft tissue or muscle pain. (PX 9, p. 8) Dr. Smucker recommended use of Mobic and Skelaxin, and suggested an epidural steroid injection series. (PX 9, pp. 8-9) Dr. Smucker placed Petitioner on a 25 pound lifting restriction and recommended that she avoid twisting or bending at the waist. (PX 9, p. 9) Petitioner had the first epidural steroid injection and saw Dr. Smucker on June 1 and Dr. Smucker's impression at that time was that she had lumbar degenerative disc disease and a disk herniation at L4/5 that was somewhat improved by the initial injection. (PX 9, p. 10) Petitioner had a second injection on June 6, 2005 and then returned to Dr. Smucker earlier than scheduled on June 17, 2005, reporting pain and swelling in her neck, shoulder girdle and arms with radiating numbness and tingling. She reported improvement in her low back and legs after the two epidural steroid injections. (PX 9, p. 11) Dr. Smucker noted that the cervicothoracic complaints had been present to varying degrees since the reported injury. He noted she had intense pain coming on intermittently on either side which he felt was consistent with myofascial pain, but ordered an upper extremity EMG to check for radiculopathy or neuropathy. (PX 9, pp. 12-13) When seen on July 27, 2005, Petitioner showed a diminished biceps reflex on the left side though other neurological testing was normal. (PX 9, pp. 13-14) Dr. Smucker felt that the diminished biceps reflex could be consistent with a radiculopathy. (PX 9, p. 14) Dr. Smucker again recommended an EMG as well as a cervical MRI. (PX 9, p. 14) An MRI was done on August 6, 2005, that showed osteophytic change and degenerative disk changes on the right at C3/4 and C5/6 with right greater than left neuroforamina narrowing at both levels. (PX 9, p. 15) An EMG was done on August 19, 2005, that showed a mild left C6 radiculopathy. (PX 9, p. 15) Dr. Smucker testified that the EMG findings were consistent with the clinical finding of diminished reflex and stenosis at C5/6 shown on the MRI. Petitioner returned to Dr. Smucker on August 26, 2005, with continuing complaints, and Dr. Smucker recommended continued work restrictions, therapy and a cervical epidural steroid injection. (PX 9, pp. 16-17) The epidural injection on October 7, 2005, provided no improvement and an appointment was set with Dr. VanFleet, with continued physical therapy. (PX 9, pp. 14-15) Petitioner was complaining of pain in her neck and in the muscles between her shoulder blades and radiating in to her arms and fingers. Her symptoms were on both sides rather than primarily on the left. (PX 9, pp. 18-19) Petitioner returned to Dr. Smucker on October 19, 2005

after having seen Dr. VanFleet that day. Dr. VanFleet had not felt that she required operative intervention at that time. Dr. Smucker's diagnostic impression remained the same, being cervical radiculopathy and degenerative disc disease. (PX 9, p. 20) As Petitioner was not considered an operative candidate, Dr. Smucker felt that he had done all he could do and released Petitioner at maximum medical improvement and to return to work. (PX 9, pp. 20-21)

Dr. Smucker opined that Petitioner's low back complaints were causally related to her first work-related accident. (PX 9, p. 21) Dr. Smucker also opined that the cervical complaints that he treated were causally related to her work accident. (PX 9, p. 22) Dr. Smucker acknowledged that he reviewed records of Petitioner's subsequent treatment that he detailed in his report attached as Exhibit 2 of his deposition, and included Petitioner's subsequent cervical fusion at C5/6. (PX 9, pp. 22-23) Based on those records and his knowledge of Petitioner's initial treatment, Dr. Smucker opined that Petitioner's cervical fusion was causally related to her March 2005 accident. (PX 9, p. 23) Dr. Smucker acknowledged that the subsequent diagnoses of Petitioner's cervical conditions as well as her complaints were consistent with what he had diagnosed. (PX 9, p. 24) On cross-examination, Dr. Smucker acknowledged that on June 17, 2005 Petitioner appeared seeking treatment for her neck and upper back, but volunteered that she had complained of her neck, shoulder girdles and upper extremities on the first day he saw her, though the degree of complaint was greater at the subsequent visit. (PX 9, pp. 32-33) He testified that throughout his treatment Petitioner had "consistently any time we reviewed the question of how did this all begin, each time she indicated that all of the above symptoms, the low back, the neck, the upper back and all that stuff began with this incident of a pulling in her back the day she was transferring someone" referring to the incident of March 21, 2005. (PX 9, pp. 33-34) Addressing his release of Petitioner without restrictions, Dr. Smucker commented, "I would also point out that this individual was leaving the community, and I have no doubt that I would have confided in her and asked her if she wanted me to give her any restrictions because we were at the end of the road and she was moving to a new community and she was hoping to find work there. And both she and I would have known that her going to a new community and having work restrictions could have made it very difficult for her to find a job." (PX 9, p. 38) Dr. Smucker reviewed the initial treatment records from Dr. Bansal and Progressive Wellness and acknowledged that they contained no reference to complaints of the neck. (PX 9, pp. 29-30) However, Dr. Smucker testified later that Petitioner and her doctors may have been focused on her then primary complaint of low back pain, just as Dr. Smucker had focused on the complaint primarily in his first visit with Petitioner, though he did note her complaints in her neck and upper extremities. (PX 9, pp. 42-45) Dr. Smucker testified that the notes that he reviewed from Dr. Bansal did not change his opinion on causation, and that he had noted that there were other medical issues that Dr. Bansal did not refer to, which would suggest the low back complaints were being focused upon to the exclusion of other present issues. (PX 9, pp. 47-48)

Petitioner testified that she continues to experience spasms and pain in her neck and low back. Petitioner testified that she no longer performs many of her household duties and that her children have taken over many of them due to her pain. Petitioner testified that she currently works as a phlebotomist for Central Illinois Cancer Care which involves only drawing blood and does not involve the lifting and moving of equipment that she was required to do previously. Petitioner testified that she avoids activities involving bending or lifting over 10 pounds. She no longer drives long distances as this exacerbates her low back and neck pain. She limits climbing stairs. Petitioner testified that she takes over-the-counter-pain medication daily for her pain.

The Arbitrator concludes:

Causal Connection.

As a result of her undisputed accident of March 21, 2005, Petitioner sustained a low back and mid-thoracic back injury. Petitioner's cervical complaints are not causally connected to her work accident.

With regard to her low and mid-back complaints, Petitioner sustained a sprain/strain which resolved by July 11, 2005, when she was examined by Dr. Orth. By her July 27, 2005 appointment with Dr. Smucker, Petitioner's treatment was focused on her neck and not her low back. Thereafter, Petitioner had no further treatment to her low back until after her alleged accident of August 15, 2006 (which is the subject of companion case number 08 WC 33076). The Arbitrator is aware that Petitioner reported periodic low back pain and complaints when examined by Dr. VanFleet on October 19, 2005; however, Dr. VanFleet recommended no treatment and primarily focused his concerns and examination on her cervical complaints. That same day, Dr. Smucker essentially released her from care and thereafter Petitioner underwent no further treatment for almost one year. The medical records through October 19, 2005 suggest that Petitioner's low and mid-back complaints plateaued by July of 2005 and any periodic complaints of back pain thereafter are more properly addressed when looking at the issue of permanency.

With regard to Petitioner's cervical complaints, the Arbitrator has concluded that Petitioner did not injure her neck at the time of her accident. This conclusion is based upon a lack of corroboration for Petitioner's testimony. Petitioner relies upon her testimony and that of Dr. Smucker to establish causation for her cervical complaints – most notably, Dr. Smucker's belief that Petitioner had cervical complaints from the time of the accident onward. Dr. Smucker relied on Petitioner's history as provided to him to support this belief; however, he never actually reviewed Dr. Bansal's medical records until late in his deposition. Even then, his opinion concerning them was speculative. If the parties wished to know what Dr. Bansal knew about Petitioner's condition when he treated her, Dr. Bansal should have been deposed. He could have clarified whether she had any true neck complaints and/or whether she was focused initially on her back complaints rather than her alleged neck complaints. As it stands, Dr. Bansal did not document any neck/shoulder complaints while he treated Petitioner. Similarly, no such complaints are noted in the initial physical therapy records. The first mention of any neck/shoulder complaints is found in the physical therapy Patient Daily Note dated April 27, 2005. However, even then, Petitioner did not attribute her complaints to the accident; rather, she attributed them to new exercises she was performing.[1] No such complaints were noted at the time of Petitioner's next visit on April 29, 2005. While Petitioner did present to Dr. Smucker on May 9, 2005 with some additional complaints besides low back pain, Dr. Smucker described it as "pain and tingling radiating not only through her lower back, but also up through the thoracic back to the neck, shoulders and arms." Petitioner's primary symptoms were of the low back, however. While Petitioner reported pain radiating up into her upper back and shoulder blades when attending physical therapy on May 12, 2005, by the time of her next appointment with Dr. Smucker on June 1, 2005, no neck or shoulder complaints were noted. Similarly, Petitioner continued with physical therapy after May 12, 2005, and, again, there was no specific mention

[1] Petitioner did not testify to any neck complaints she associated with physical therapy.

of neck or shoulder complaints during this time until June 15, 2005, when Petitioner reports having gone to Urgent Care the day before because of sharp neck pain. (PX 6, pp. 69-79) Petitioner herself did not introduce the records of Urgent Care into evidence at arbitration; Respondent did. These records reflect a new onset of complaints. It is after this visit to Urgent Care that Dr. Smucker documents, for the first time, a diagnosis of cervicothoracic complaints. Petitioner, however, never brought her visit to Urgent Care on June 14, 2005 to Dr. Smucker's attention. The Arbitrator also notes that if Petitioner did, in fact, experience neck pain at the time of her accident why didn't she mention that when seen at Urgent Care on June 14, 2005? The Arbitrator's determination is also based upon significant gaps in treatment and Petitioner's denial to Dr. Matz of any problems before August 15, 2006 which undermines her credibility. The Arbitrator was not persuaded by Petitioner's history as provided in the Intake Form to Dr. Kube dated September 21, 2006. On the one hand, it was not accurate (completely failing to mention the alleged August 15, 2006 accident with the American Red Cross, if indeed it occurred). Furthermore, that history was provided only days after Petitioner filed her Application for Adjustment of Claim in this matter and after undergoing no treatment in almost one year. Petitioner's motivation and credibility are both called into question by these events and history.

Temporary Total Disability.

Based upon Petitioner's testimony and the medical records and depositions submitted into evidence, and in light of the finding on causation above, the Arbitrator finds that Petitioner was temporarily and totally disabled from March 28, 2005 through July 11, 2005, a period of 15 1/7weeks.

Medical Expenses.

In light of the Arbitrator's causation determination, Petitioner is awarded those medical expenses incurred by her in connection with her low back and mid-back complaints and treatment through July 11, 2005. Petitioner is not awarded any bills incurred in connection with the visit to Urgent Care on June 14, 2005. Respondent shall receive credit for any amounts shown to have been paid by Respondent's employer's sponsored health insurance, subject to Respondent's obligation to hold Petitioner harmless from any claims for reimbursement from said insurance as set forth in Section 8(j) of the Act.

Nature and extent.

As a result of her work related accident, Petitioner sustained a low back and mid-back injury, amounting to strains. Petitioner underwent physical therapy, two epidural steroid injections, restricted duty, and the use of pain medications. Medical records suggest periodic activity-related flare-ups or exacerbations of pain. The Arbitrator awards permanent partial disability of 5% of a person-as-a-whole.

****